Nassau County Department of Mental Health
SPOE Referral Form

Services Referred to (**check all that apply**):		Case Management		ACT		AOT

1. Applicant Name:	**8. Next of Kin/Emergency Contact:**
2. Address:	**8a. Address:**
3. Telephone No.: **4. Gender: M F**	
5. SSN:	**8b. Telephone Number:**
6: DOB **7. AGE:**	**8c. Relationship to Applicant:**

Applicant Demographics:

12**. Ethnicity:**

( ) White (Non-Hispanic)
( ) Black (Non-Hispanic)
( ) Latino/Hispanic
( ) Asian-Asian American
( ) Native American
( ) Pacific Islander
( ) Other or dual (specify)

13. **Current Educational Level:**

( ) Some grade school 1-8th grade
( ) Some HS 9-12th grade, but no diploma
( ) Vocational business training
( ) College degree
( ) Ungraded
( ) Other:
( ) Completed grade school
( ) HS diploma or GED
( ) Some college, but no degree
( ) Masters Degree
( ) No formal education

14**.Current Employment Status:**

( ) Full Time ( ) None
( ) Part Time
( ) No Employment
( ) Other

15. **Criminal Justice History**

( ) Currently incarcerated-jail ( ) CPL 330.20 ( ) Probation ( ) Parole
( )Alternative to Incarceration (any voc or addiction treatment) ( ) Currently incarcerated-prison
( ) Released from jail/prison in the last 30 days ( ) Other

16. **Primary Language:**

( ) English ( ) Spanish ( ) Chinese ( ) Creole
( ) French ( ) Russian ( ) German ( ) Greek
( ) Italian ( ) Japanese ( ) Vietnamese ( ) Urdu
( ) Hindi ( ) No language ( ) American Sign Language
( ) Other:

17. **English Proficiency (if item 12 is other than English):**

( ) Does not speak English
( ) Poor
( ) Fair
( ) Good
( ) Excellent

18. **Current Marital Status**:

( ) Single, never married
( ) Currently married
( ) Cohabiting with significant other/Domestic Partner,
( ) Divorced/separated
( ) Widowed

19. **Custody Status of Children**

( ) No Children
( ) Have children all >18 yrs. old
( ) Minor Children currently in client's custody
( ) Minor Children not in client's custody but have access
( ) Minor Children not in client's custody – no access

20. **Referral Information**:

Name: _____ Title: _____ Agency: _____ Phone Number: _____

21. **Referral source***:*

( ) Self, family, or friend ( ) State Psychiatric Center (inpatient) ( ) General Hospital (inpatient) ( ) Mental Health residential
( ) Mental Health outpatient ( ) Emergency nonresidential program ( ) CSP mental health program ( ) Local mental health practitioner
( ) General hospital ER ( ) Other medical provider ( ) MR/DD facility ( ) Substance abuse program
( ) Police ( ) Family Court ( ) Criminal Court ( ) Jail, penitentiary etc.
( ) Probation ( ) Parole ( ) Shelter for homeless ( ) Other:_____

22. **Date of Referral**: _____/_____/_____ (MONTH, DAY, YEAR)

ALL APPLICATIONS MUST INCLUDE PSYCHOSOCIAL AND PSYCHIATRIC EVALUATION SIGNED BY PSYCHIATRIST OR NURSE PRACTIONER. EVALUATIONS MUST HAVE BEEN COMPLETED WITHIN THE YEAR.

23. **Current or Last Services (check all that apply):** ( ) No prior service

	Historic	Current	Agency name (if known)	Primary provider name (If known)	Phone Number
State Psychiatric Center (Inpatient)	❑	❑			
General Hospital – Psychiatric inpatient	❑	❑			
Mental Health Residential	❑	❑			
Mental Health Outpatient	❑	❑			
CSP Mental Health Program	❑	❑			
Case Management	❑	❑			
Emergency Mental Health (nonresidential)	❑	❑			
Prison, jail, or court	❑	❑			
Local Mental Health Practitioner	❑	❑			
Substance Abuse treatment	❑	❑			
Medical Treatment	❑	❑			
Other	❑	❑			

If no current services, specify date of last services:

24. **Living Situation at Time of Referral*:***

( ) Homeless (streets) ( ) Homeless (shelter) ( ) Lives alone
( ) Lives with spouse ( ) Lives with parents ( ) Assisted/Supported living/CR
( ) Supervised living ( ) Nursing Home Medical Setting ( ) Psychiatric Hospital
( ) Correctional facility ( ) Lives with other relatives
( ) Other: _____

25. **Living Situation at Time of Discharge*:***

( ) Homeless (streets) ( ) Homeless (shelter) ( ) Lives alone
( ) Lives with spouse ( ) Lives with parents ( ) Assisted/Supported living/CR
( ) Supervised living ( ) Nursing Home Medical Setting
( ) Correctional facility ( ) Lives with other relatives
( ) Other: _____

26. **Entitlements and Income: (Check appropriate column)**

Benefits or Insurance	Currently receives	Pending Application Submitted	Eligible no application submitted	Ineligible	Unknown
Social Security	❑	❑	❑	❑	❑
SSI/SSD	❑	❑	❑	❑	❑
Public Assistance	❑	❑	❑	❑	❑
Veterans	❑	❑	❑	❑	❑
Medicare/Medicaid	❑	❑	❑	❑	❑
Food Stamps	❑	❑	❑	❑	❑
Pension	❑	❑	❑	❑	❑
Wages/earned income	❑	❑	❑	❑	❑
Worker's Comp	❑	❑	❑	❑	❑
Unemployment	❑	❑	❑	❑	❑
Private insurance/third party payer	❑	❑	❑	❑	❑
Trust Fund	❑	❑	❑	❑	❑
Medication Grant	❑	❑	❑	❑	❑
Other	❑	❑	❑	❑	❑

27. Outpatient Treatment Provider

Name of Agency/Private Practitioner: _____

Contact Person: _____

Telephone No.: _____

Clinical

28. **Psychiatric Diagnosis:**

Axis I:
Primary: _____ Code: ____. ___
Secondary: _____ Code: ____. ___

Axis II:
Primary: _____ Code: ____. ___
Secondary: _____ Code: ____. ___

Axis III:
Primary: _____ Code: ____. ___
Secondary: _____ Code: ____. ___

Axis V: _____ V code: _____ Medical ICD9 code _____

Utilization of High Intensity Services

29. Number of psychiatric hospitalizations in past 12 months.
Enter number: _____

30. Number of psychiatric hospitalizations in past 24 months. Enter number: _____
31. Number of days of psychiatric hospitalization in State Psychiatric Facilities in past 25 months. Enter number: _____
32. Number of psychiatric ER Visits in the past 12 months Enter number: _____
33. Number of psychiatric ER Visits in the past 34 months. Enter number: _____

34. Has Documented History of Violence to Self or Others: Yes No
a) Date (s): _____

35. Nassau County Case Management Acuity Scale

	Need Dimension	1	2	3	4	5
1	Treatment Participation	Has not required assistance for over three months	Has required assistance during last six months, but not currently	Requires assistance to help maintain treatment	Minimal treatment participation	Refuses all Treatment
2	Medication Compliance	Has not required assistance for over three months	Has required assistance during last three months, but not currently	Requires assistance to help maintain medication compliance	Minimal compliance	No compliance with medication regimen
3	Housing	Stable housing for more than three months	Stable housing for less than three months	Requires assistance to help maintain housing	Unstable housing situation	Housing needs are unmet
4	Basic Needs	Has not required assistance for over three months	Has required assistance during last three months, but not currently	Requires assistance to help maintain basic needs	Basic Needs are only minimally met	Basic Needs are not met
5	Benefits and Income Stream	Has not required assistance for over three months	Has required assistance during last three months, but not currently	Requires help to manage benefits and income stream	Has applied for but not yet received benefits	None; not applied for
6	Substance Abuse	None apparent for more than three months	None apparent now, but within last three months some use has occurred	Occasional minor impairment	Frequent minor impairment	Frequent, major impairment
7	Danger to Self or Others	None apparent for more than three months	Not apparent currently, but has required assistance within last three months	Possible	Probable	Imminent
8	Crisis Incidents	Has not required assistance for over three months	Does not require assistance currently, but has required it within last three months	Requires help to handle intermittent crisis	Frequent crisis	Continual crisis

Circle appropriate acuity level box for each need dimension listed in left most column. Clients who achieve a rating of 1 for all 8 dimensions for three consecutive months are to be discharged from Case Management unless they are mandated to ICM.

OFFICE USE ONLY

Recommendations

36. **Recommended for SPOE priority services,**

Yes _____ No _____ Date: _____, _____

If yes, type of SPOE Program referred to: (check all that apply): ( ) Case Management ( ) ACT ( ) AOT

If yes, Program or Agency Name(s):

If yes, but services are unavailable, what are alternative recommendations:

If no, describe any alternative recommendations:

Name, Title and Phone Number of person completing this information:

Name: **Title:** **Phone Number:**

AOT APPLICATIONS PLEASE COMPLETE NEXT PAGE

Nassau County Department of Mental Health
SPOE Referral Form

AOT APPLICATIONS ONLY

Completion of additional information is required

1. ***Hospitalization history resulting from non-compliance with medication***:

Name of Hospital	*Date from*	*To:*

Note: If exact date is unknown, the year of hospitalization ***must*** *be listed*.

2. ***Act(s) or threat(s) of violence:*** ☐ ***YES*** ☐ ***NO***

If yes, provide the date(s): _____

Describe the incident(s) or threat(s):

3. ***Currently compliant with medication :*** ☐ ***YES*** ☐ ***NO***

Please provide a brief narrative as to why this individual would benefit from an AOT Order
